Documentation Expectations
Prior Authorization Request for Additional Services

Client Last Name: **Must be included** Client First Name: **Must be included**

Medicaid Number: **Must be included** Date of Birth: _____

Health Condition/Risk: **Must include name of health condition/risk or high risk condition. Do not include ICD-9 codes**

Describe why additional services are needed:
Expectation that clear description of why additional services are needed will be included. The description must include summary of why needs were not addressed with the original authorization for services.

Prior authorization request for:
Case manager must indicate what service(s) they are requesting for the client.
_____**# Comprehensive visit**s _____**# Face-to-face follow visits** _____**# Telephone follow visits**

Request must be signed by case manager and must include credentials	**Request must be dated**	
Case manager signature	Date	Public Health Region

Case manager must print name and credentials	**Provider Name must be included.**	**TPI Must be included**
Case manager name (please print)	Case management provider name	TPI number

( ) -	**Must include fax number to allow response to be returned**	
Provider phone number	Provider fax number	Provider e-mail

Reminder: This form must be accompanied by a copy of the intake, family needs assessment, service plan, service plan addendums, follow-up notes and any other documentation that supports the request. **If all documents are not received the request will be denied.**

Note: Prior authorization is a condition of reimbursement for all services provided after September 1, 2003. Prior authorization is not a guarantee of payment.